Case Management Services

Billing

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

Important Telephone Numbers

The Wisconsin Medicaid Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m. - 5:00 p.m. (M-F)

* Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Table of Contents

Preface

The Wisconsin Medicaid and BadgerCare Case Management Handbook is issued to case management providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Case Management Handbook consists of the following sections:

- General Information.
- Covered and Noncovered Services.
- Billing.

In addition to the Case Management Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

Claims Submission

Claims submitted electronically have the same legal requirements as paper claims and are subject to the same processing requirements.

Billed Amounts

Case management providers must always bill Wisconsin Medicaid their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to private-pay recipients. Providers who do not have a usual and customary charge must bill Wisconsin Medicaid the estimated cost for services provided. Providers must not discriminate against recipients by charging a higher fee for the same service than is charged to a private-pay patient.

Paper Claims Submission

Submit claims for case management services on the National CMS 1500 claim form. Refer to Appendices 1 and 2 of this section for a sample form and completion instructions.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal form supplier.

Mail completed claims for payment to:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

For ongoing monitoring and service coordination, case management providers must accrue billable time during a month and bill only *once* per recipient, per month.

Wisconsin Medicaid allows more than one month's services on a single claim, but each month's ongoing monitoring and service coordination must appear on a separate detail line. Reimbursement is limited to staff time paid for by the case management provider.

Paperless Claims Submission

As an alternative to submission of paper claims, Wisconsin Medicaid processes claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as paper claims and are subject to the same processing requirements. Providers submitting electronically usually reduce their claims submission errors and processing time. For additional information on alternative claims submission, contact:

Wisconsin Medicaid
Electronic Media Claims
6406 Bridge Rd
Madison WI 53784-0009
(608) 221-4746

Submission of Claims

Wisconsin Medicaid must receive all claims for services provided to eligible Medicaid recipients within 365 days from the date of service. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Refer to the Claims Submission section of the All-Provider Handbook for information about exceptions to the claims submission deadline and submission requirements to Late Billing Appeals.

Refer to the Covered and Noncovered Services section of this handbook for more information about case management covered services.

Target Population Codes

The case management claim must identify the recipient's " target populations" in Element 21 of the claim form.

Refer to the Covered and Noncovered Services section of this handbook for a listing of allowable target population codes. In all cases, target population codes ending in the letter "B" are used to identify recipients receiving funding through the Community Options Program (COP) for any of the case management functions in a given month.

Note: The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure is *not* used to identify or describe the target populations.

Procedure Codes

Wisconsin Medicaid denies submitted claims that do not have allowable Healthcare Common Procedure Coding System (HCPCS) procedure codes. Refer to the Covered and Noncovered Services section of this handbook for a listing of allowable procedure codes.

Bill ongoing monitoring and service coordination only once per month. *On individual dates of service*, case managers may either record their actual time (e.g., 3 minutes, 45 minutes) or accumulate the time spent on case management services on that day and round to the nearest one-tenth hour.

On a monthly basis, case managers must add up the time for the individual dates of service. If actual time was recorded on individual dates of service, round the accumulated time at the end of the month to the nearest one-tenth hour. Refer to Appendix 3 of this section for rounding guidelines.

For example, a case manager has billable contacts on three days during a month: a 1 hour and 15 minute meeting with a recipient (including travel and recording time), a 10 minute phone call with a collateral (refer to the Covered/Noncovered Services section of this handbook for a definition of a collateral), and another 20 minute phone call with a collateral.

If the case manager records actual time, these are accumulated at the end of the month to 1 hour and 45 minutes and billed to Wisconsin Medicaid as 1.8 units of service. If these are rounded on individual days (to 1.3 units, .2 units, and .4 units), they are accumulated at the end of the month and billed to Wisconsin Medicaid as 1.9 units of service. Refer to Appendix 3 of this section for more information on rounding guidelines for units of service.

Place of Service Codes

Place of service (POS), Element 24B, is always "0" (other), except when billing for institutional discharge planning. Refer to Appendix 3 of this section for a list of allowable POS codes. Refer to Appendix 2 of this section for claim form completion instructions.

Type of Service Codes

Type of service, Element 24C, is always "9" (other medical service) on the claim form. Refer to Appendix 2 of this section for claim form completion instructions.

Wisconsin Medicaid denies submitted claims that do not have allowable Healthcare Common Procedure Coding System (HCPCS) procedure codes.

Follow-Up to Claims Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status Report as either paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing.

Because of the claim filing deadline (365 days from the date of service), it is critical that the case management provider understand these follow-up procedures.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for more information on filing Adjustment Request Forms.

To be reimbursed for additional case management time that may have been omitted from the original claim, providers are required to file an Adjustment Request Form.

Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing.

Appendix

Appendix 1

Sample Completed CMS 1500 Claim for Case Management Services

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) [P] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [x] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 64A . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	12	02	02			0	9	W7051		1	XXX XX	1.0				
2	12	15	02			0	9	W7061		1	XXX XX	1.0				
3	12	15	02			0	9	W7071		1	XXX XX	1.0				
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I. M. Authorized MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 86754321
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix

Appendix 2

National CMS 1500 Claim Form Completion Instructions for Case Management Services

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female by placing an "X" in the appropriate box.

Mother/Baby Claims

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service (DOS) and the mother of the infant is a Medicaid recipient. To bill for an infant using the mother's Medicaid identification number, enter the following:

Element 1A: Enter the mother's 10-digit Medicaid identification number.

Element 2: Enter the mother's last name followed by "newborn."

Element 3: Enter the ***infant's*** date of birth.

Element 4: Enter the mother's name followed by "mom" in parentheses.

Element 21: Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Do not enter *anything* in this element.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number (not required)

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the three-digit target population code for each target population to which the recipient belongs. Refer to the Covered and Noncovered Services section of this handbook for a list of target population codes.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- For assessments and case planning, if the service was performed on more than one date of service, indicate the last date of service on the claim form.
- For ongoing monitoring and service coordination, if the service was performed on more than one date of service within the month, indicate the last date the service was performed in each month as the date of service on the claim form.

Although a given month's ongoing monitoring may only be billed once, more than one month's ongoing monitoring may be billed on a single claim form. In that case, use one detail line for each month's ongoing monitoring with the date of service determined as described above.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit place of service (POS) code for each service. The POS code will be "0," except when billing for discharge planning.

Element 24C — Type of Service

Enter "9" for the type of service code. (Type of service is always "other medical service.")

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Refer to the Covered and Noncovered Services section of this handbook for a list of allowable procedure codes.

Element 24E — Diagnosis Code

Enter the target population code or enter the line number that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the total number of hours billed on each line item. Round to the nearest one tenth hour.

Element 24H — EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (optional)

Provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid (not required)

Element 30 — Balance Due

Enter the balance due. This will be the same amount as appears in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 3
Rounding Guidelines and Allowable Place of Service Codes

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s). Refer to the Claims Submission chapter of this section for more information about how to bill for case management services.

Billing in One-Tenth Hour Increments

Time (in minutes)	Unit(s) Billed
1 - 6	.1
7 - 12	.2
13 - 18	.3
19 - 24	.4
25 - 30	.5
31 - 36	.6
37 - 42	.7
43 - 48	.8
49 - 54	.9
55 - 60	1.0
	etc.

The following chart lists the allowable place of service codes.

Place of Service Codes

Code	Description
0	Other
1	Inpatient Hospital
7	Nursing Home
8	Skilled Nursing Facility

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

Collateral

A collateral is anyone who has direct supportive contacts with the recipient. Collaterals include family members, friends, service providers, guardians, housemates, or school officials.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS) and Wisconsin Medicaid.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Emergency services

Those services which are necessary to prevent the death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the providers' Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software or Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS) in order to supplement CPT codes.

HMO

Health Maintenance Organization. Provides health care services to enrolled recipients.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for all medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:
    1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
    2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
    3. Is appropriate with regard to generally accepted standards of medical practice;
    4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

POS

Place of service. A single-digit code which identifies where the service was performed.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

Index